Software Engineering Institute

Predicting Software Assurance Using Quality and Reliability Measures

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Executive Overview

Processes used for improving the quality of a system emphasize reducing the number of possible defects, but quality measures and the techniques applied to improved quality can vary in effectiveness and importance depending on the consequences of a defect and whether the measures and techniques are applied to hardware or software. Considerable experience exists on measuring hardware quality. For example, the mean time between failures is often used to measure the quality of a hardware component. Consistently long periods between failures is evidence of general hardware reliability.

For measuring safety, the mean time between failures is not sufficient. We need to identify and mitigate defects that could create hazardous conditions, which could affect human life. For security, the consideration of impact also applies. Voting machine quality includes accurate tallies, but also includes mitigating design defects that could enable tampering with the device.

There is an underlying assumption that a hardware device is perfectible over time. A reduction in known defects improves the quality of a hardware device. A comparison of the failure distributions for hardware and software shows that the same reasoning does not apply to the reliability or security of a software component. The *bathtub curve* shown in Figure 1 illustrates the failure distribution for hardware failures. This curve consists of three parts: a decreasing failure rate (of early failures), a constant failure rate (of random failures), and an increasing failure rate (of wear-out failures) over time. Defect modeling of hardware failures can identify defects that could be reduced by manufacturing and design changes.

A simple defect model is often an enumeration of development errors after they have occurred. But a software system that has had no security or reliability failures is not necessarily secure or reliable. The defects appear only when specific operating conditions arise. The failure distribution curve for software, also shown in Figure 1, reflects changes in operational conditions that trigger defects as well as new faults introduced by software upgrades. The reduction of errors between updates can lead system engineers to make predictions for a system based on the false assumption that software is perfectible over time. The assumption should rather be that complex software systems are never error-free.

Figure 1: Hardware and Software Failures Over Time[1]

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1   [Pan 1999]

The 2005 *Department of Defense Guide for Achieving Reliability, Availability, and Maintainability* (RAM) noted that known defects are not a good predictor of software reliability. Too little reliability engineering was given as a key reason for the reliability failures by the DoD RAM guide. This lack of reliability engineering was exhibited by

- failure to design in reliability early in the development process

- reliance on predictions (use of reliability defect models) instead of conducting engineering design analysis

Improved software reliability starts with understanding that the characteristics of software failures require analysis techniques distinct from those used for hardware reliability.

Software security shares many of the same challenges as software quality and reliability. Modeling security defects for software systems does not provide a prediction capability. We need to assess how engineering choices proactively reduce the likelihood of security faults. Just removing defects does not ensure improved security, since defects are identified and prioritized based on specified requirements and effective security is dependent on operational execution.

The approach recommended for software reliability in the DoD RAM guide is applicable to securing software systems. A quality measure for an engineering decision can be based on how that choice affects the injection or removal of defects. For example, a review of a hardware disk drive design would check the techniques used manage read errors or surface defects. A review of a software design might need to verify that the software engineering design choices sufficiently mitigate a fault. Hardware reliability, such as for a disk drive, can draw on documented design rules based on actual use. Software reliability has not matured to the same state. A description of the specific engineering decisions and the justification of those choices must be provided for the review. An assurance technique called an *assurance case* provides a way to document the reasoning and evidence that led to engineering choices, making them transparent for further analysis and verification.

The SEI has detailed size, defect, and process data for over 100 software development projects. The projects include a wide range of application domains and project sizes. Five of these projects focus on specific security- and safety-critical outcomes. This report includes a discussion of how these five projects could provide potential benchmarks for ranges of quality performance metrics (e.g., defect injection rates, removal rates, and test yields) that establish a context for determining very high quality products and predicting safety and security outcomes.

Many of the Common Weakness Enumerations (CWEs),[2] such as the improper use of programming language constructs, buffer overflows, and failures to validate input values, can be associated with poor quality coding and development practices. Improving quality is a necessary condition for addressing some software security issues.

Demonstrating that improving quality can improve security requires more careful analysis. Capers Jones has analyzed over 13,000 projects for the effects of general practices such as inspections, testing, and static analysis, have on improving software quality [Jones 2012]. His analysis shows

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[2]   cwe.mitre.org

that a combination of techniques is best. Appendix B discusses why quality cannot be tested in. Static analysis has limitations that can be compounded by the lack of other quality practices such as inspections. This report includes a discussion of Heartbleed, a vulnerability in OpenSSL[3] (an open source implementation of the secure socket layer protocol). Heartbleed is a good example of the limited effectiveness of current software assurance tools. Kupsch and Miller noted that, "Heartbleed created a significant challenge for current software assurance tools, and we are not aware of any such tools that were able to discover the Heartbleed vulnerability at the time of announcement" [Kupsch 2014]. But Heartbleed, which was caused by a failure to validate input data, would be expected to be found by a good code inspection.

The underlying problem is that neither testing nor static analysis can be used to evaluate engineering decisions. The Consortium for IT: Software Quality (CISQ) has developed specifications for automating the measurement of software reliability, security, performance efficiency, and maintainability [CISQ 2012]. The CISQ assessment of the structural quality of software is based on applying rules of good coding practices (*Quality Rules*). The CISQ approach, like static analysis, is based on the analysis of developed source code; but there is a significant difference between using the Quality Rules and applying static analysis. The Quality Rules incorporate software engineering recommendations, such as the use of vetted libraries that prevent specific vulnerabilities, rather than identifying defects after they have been injected.

Our research suggests that implementing systems with effective operational security requires incorporating both quality and security considerations throughout the lifecycle. Predicting effective operational security requires quality and reliability evidence and security expert analysis in each step of the lifecycle. If defects are measured, 1-5% of defects should be considered to be security vulnerabilities. It is also feasible that when security vulnerabilities are measured, code quality can be estimated by considering security vulnerabilities to be 1-5% of the expected defects.

This report provides further analysis of the opportunities and issues involved in connecting quality, reliability, and security. Because our sample set is small, further evaluation is needed to see if the patterns suggested by our analysis continue to hold.

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[3]   CVD id CVE-2014-0160 (MITRE; "National Vulnerability Database") http://web.nvd.nist.gov/view/vuln/detail?vulnId=CVE-2014-0160

Abstract

Security vulnerabilities are defects that enable an external party to compromise a system. Our research indicates that improving software quality by reducing the number of errors also reduces the number of vulnerabilities and hence improves software security. Some portion of security vulnerabilities (maybe over half of them) are also quality defects. This report includes security analysis based on data the Software Engineering Institute (SEI) has collected over many years for 100 software development projects. Can quality defect models that predict quality results be applied to security to predict security results? Simple defect models focus on an enumeration of development errors after they have occurred and do not relate directly to operational security vulnerabilities, except when the cause is quality related. This report discusses how a combination of software development and quality techniques can improve software security.

1   Introduction

The Common Weakness Enumeration (CWE)[4] is a list of over 900 software weaknesses that resulted in software vulnerabilities exploited by attackers. Many of them, such as the improper use of programming language constructs, buffer overflows, and failures to validate input values, can be associated with poor quality coding and development practices. Quality would seem to be a necessary condition for software security.

A reduction in known software defects is not necessarily a predictor for either improved security or reliability. For reliability, we can use statistical measures, such as the mean time between failures (MTBF), for hardware reliability since hardware failures are often associated with wear and other errors that are often eliminated over time. But software weaknesses, such as those listed in the CWE, exist when a software system is deployed; they may not be known for some time because the conditions, which may require external attacks and could cause a failure, have not yet occurred (in either testing or in operation). A system that has had no reliability or security failures is not necessarily reliable or secure when the threat or use environment changes.

Software security cannot be confirmed because there is no current means for establishing that all vulnerabilities have been removed. Confirmation of reliability faces a similar problem. The 2005 *Department of Defense Guide for Achieving Reliability, Availability, and Maintainability* (RAM) noted that known reliability defects are not a good predictor for software reliability. Too little reliability engineering was given as a key reason for the reliability failures by the DoD RAM guide. This lack of reliability engineering was exhibited by

- failure to design-in reliability early in the development process

- reliance on predictions (use of reliability defect models) instead of conducting engineering design analysis

Defect models that predict quality could be applied to predicting security if all security vulnerabilities were quality related. However, a simple defect model is often an enumeration of development errors after they have occurred. In practice, defect tracking is not consistently performed. Too few projects track defects prior to system and integration testing. Most Agile development projects do not consider anything to be a defect until the code is submitted for integration. Defect tracking in system testing and integration can be inconsistent and available data is often dependent on the development methodology in use (waterfall, Lean, SCRUM, etc.) and the level of data tracked as part of the development project. Removing defects could improve our confidence that the system has improved security, but we need to base that judgment on concrete evidence and not just on opinions of the developers or validators.

Software assurance, defined as *the level of confidence we have that a system behaves as expected and the security risks associated with the business use of the software are acceptable*, would be supported by effective quality and reliability predictions. Software assurance techniques can be

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4   cwe.mitre.org

used to assemble evidence that should increase our confidence that a system's behavior will be valid (including expected security). The strength of a software security assurance claim must depend, in part, on an assessment of the engineering decisions that support it (comparable to reliability) and, in part, by the evidence that defects have been removed (comparable to quality).

The use of existing standards that address software assurance should also support claims of quality, reliability, and security. There are many recommendations, best practices, and standards, but, to date, limited research confirms the effectiveness of them with respect to software quality, reliability, or security. NIST 800-53 has hundreds of practices recommended for federal agencies and is seeking feedback on results. Microsoft's Security Development Lifecycle[5] emphasizes preventing the creation of vulnerabilities and provides data from their experience to support use in product development and sustainment, but use by other organizations has not been validated. The Build Security In Maturity Model[6] (BSIMM) contains information about security initiatives in 67 organizations, but this information is focused at an organizational level and has not been associated with publicly available operational results.

This report includes an analysis of various aspects of quality and reliability in an effort to determine their applicability to predicting operational security results. There are no clear answers, but several analysis threads provide strong indicators of potential value and warrant further consideration. This report is intended to inform executives, managers, and engineers involved in technology selection and implementation about the value of quality and reliability data in supporting security needs.

Section 2 describes the software assurance case and its value in assembling evidence from a range of sources to support a desired outcome (claim). In a sense, this report is the start of an assurance case for predicting security from quality and reliability data.

Section 3 describes five projects that delivered excellent security or safety-critical results while focusing on high-quality delivery. The way in which these results were obtained provides useful insights into relationships among quality, reliability, and security.

Section 4 describes two case studies of software failures in which quality and security results appear to be related.

Section 5 describes other efforts underway to evaluate quality and security that are providing useful results.

Section 6 summarizes the current information we have that links quality and reliability to security and the feasibility of predicting security results. This section also proposes future research needs for others to consider.

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[5]   https://www.microsoft.com/security/sdl/default.aspx?mstLoc

[6]   http://bsimm.com/

2 Assurance

There is always uncertainty about a software system's behavior. At the start of development, we have a very general knowledge of the operational and security risks that might arise as well as the security behavior that is desired when the system is deployed. A quality measure of the design and implementation is the confidence we have that the delivered system will behave as specified. Determining that level of confidence is an objective of software assurance, which is defined by the Committee on National Security Systems [CNSS 2009] as

> *Software Assurance: Implementing software with a level of confidence that the software functions as intended and is free of vulnerabilities, either intentionally or unintentionally designed or inserted as part of the software, throughout the lifecycle.*

At the start of a development cycle, we have a limited basis for determining our confidence in the behavior of the delivered system; that is, we have a large gap between our initial level of confidence and the desired level of confidence. Over the development lifecycle, we need to reduce that confidence gap, as shown in Figure 2, to reach the desired level of confidence for the delivered system.

Figure 2:   Confidence Gap

With existing software security practices, we could apply source-code static analysis and testing toward the end of the lifecycle. For the earlier lifecycle phases, we need to evaluate how the engineering decisions made during design affect the injection or removal of defects. Reliability depends on identifying and mitigating potential faults. Software security failure modes are exploitable conditions, such as unverified input data. A design review should confirm that the business risks linked to fault, vulnerability, and defect consequences have been identified and mitigated by specific design features. Software-intensive systems are complex; it should not be surprising that

the analysis done, even by an expert designer, could be incomplete, could overlook a risk, or could make simple but invalid development and operating assumptions.

Our confidence in the engineering of software should be based on more than opinion. If we claim the resulting system will be secure, our confidence in the claim will depend on the quality of evidence provided to support the claim, on confirmation that the structure of the argument about the evidence is appropriate to meet the claim, and that sufficient evidence is provided. If we claim that we have reduced vulnerabilities by verifying all inputs, then the results of extensive testing using invalid and valid data provides evidence to support the claim.

We refer to the combination of evidence and argument as an assurance case.[7]

> *Assurance case: a documented body of evidence that provides a convincing and valid argument that a specified set of critical claims about a system's properties are adequately justified for a given application in a given environment.*

An analysis of an assurance case does not evaluate the process by which an engineering decision was made. Rather it is a justification of a predicted result based on available information. An assurance case does not imply any kind of guarantee or certification. It is simply a way to document the rationale behind system design decisions.

Doubts play a significant role in justifying claims. During a review, an assurance case developer is expected to justify through evidence that a set of claims have been met. A typical reviewer looks for reasons to doubt the claim. For example, a reviewer could

- **Doubt the claim.** There is information that contradicts a claim.
- **Doubt the argument.** For example, the static analysis that was done does not apply to a claim that a specific vulnerability has been eliminated or the analysis did not consider the case in which the internal network has been compromised.
- **Doubt the evidence.** For example, the security testing or static analysis was done by inexperienced staff or the testing plan did not give sufficient consideration to recovery following a compromise.

Quality and reliability can be considered potential evidence to be incorporated into an argument about predicted software security. The remainder of this section describes an example assurance case and the ways in which confidence is increased as evidence is assembled.

2.1 DoD Assurance Case Example

An assurance case can be developed for a system with software assurance as a segment of the argument. Implicit assurance cases appear in all DoD system acquisitions. Key performance param-

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[7] Assurance cases were originally used to show that systems satisfied their safety-critical properties. For this use, they were (and are) called *safety cases*. The notation and approach used in this report have been used for over a decade in Europe to document why a system is sufficiently safe [Kelly 1998, Kelly 2004]. The application of the concept to reliability was documented in an SAE Standard [SAE 2004]. In this report, we extend the concept to cover system security claims.

eters (KPPs) are the system characteristics essential for delivery of an effective military capability. All DoD projects have some number of KPPs to satisfy to be considered acceptable from an operational perspective. For example, any DoD system that must send or receive information externally is required to fulfill the Net-Ready KPP (NR-KPP), which requires that it continuously provide survivable, interoperable, secure, and operationally effective information exchanges, one of the security characteristics shown in Figure 3.

Figure 3: NR-KPP Claim

When performing an assurance case analysis of a completed design, the outcome is rather black and white: either design artifacts are complete and sufficient or they are not. But our confidence in a proposed approach can be considered at various points in the system development lifecycle as show in Figure 4. We need a target for such reviews. How do we determine we are making progress towards that target?

The objective in this example is having sufficient confidence that the NR-KPP claim has been met. Fairly early in an acquisition lifecycle, we need to at least outline how we plan to justify that claim. What evidence will we need to eventually provide? What is the argument that such evidence justifies the claim? For functional claims, testing often provides such evidence and successful unit tests can show we are making progress toward meeting the functional claims at delivery. A series of failed functional tests would raise doubts about the claims.

Our confidence in the NR-KPP claim increases as doubts raised during the reviews are resolved or as the argument and evidence required for desired assurance are revised and improved. We create a confidence map from the doubts raised; resolving them increases our level of confidence in the claim.

Figure 4: Confidence Reviews

The next section describes ways in which quality and reliability evidence was assembled to evaluate how selected projects achieved good security and safety-critical results.

3 Analysis of Quality Cases

3.1 SEI Data[8]

The SEI has detailed size, defect, and process data for more than 100 software development projects. This inventory is growing and may double in size in the near future. The projects include a wide range of application domains. This data supports potential benchmarks for ranges of quality performance metrics (e.g., defect injection rates, removal rates, and test yields) that establish a context for determining very high quality products. The following types of information are available for each project:

- summary data that includes project duration, development team size, cost (effort) variance, and schedule variance

- detailed data that includes the planned and actual for each product component: size (added and modified lines of code [LOC]), effort by development phase, defects injected and removed in each development phase, and date of lifecycle phase completion

A subset of this data is provided by high-quality projects reporting few or no defects found in production. Five of these projects were identified as successful safety-critical or security-critical implementations and have been selected for our analysis. These selected projects range in size from 30,000 to 3,000,000,000 LOC and include safety-critical medical devices, the Selective Service registration system, and a system subjected to a security audit. Quality for these selected projects was evaluated using software defect injection and removal data from quality modeling capabilities that implemented the SEI Team Software Process (TSP) [Davis 2003]. We analyzed this data to identify possible correlations between modeling quality and security, as well as unique characteristics used for these systems that led to a minimal number of defects discovered in the operational production environment.

Table 1: Selected TSP Project Data

Project	Type	Post Release Security or Safety Critical Defects	Defect Density [Defects/MLOC]	Size [MLOC]
D1	Safety Critical	20	46.1	2.8
D2	Safety Critical	0	4.4	0.9
D3	Safety Critical	0	9.2	1.3
A1	Secure	0	91.7	0.6
T1	Secure	0	20	0.03

Four of these projects reported no post release safety-critical or security defects in the first year of operation. One had twenty reported defects in operation. Three projects were implemented with very high quality (20 or less defects per million lines of code [MLOC]). According to Capers

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Jones [Jones 2011], the average defect level in the U.S. is 0.75 defects per function point or 6000 per MLOC for a high-level language. Very good levels would be 600 to 1000 defects per MLOC and exceptional levels would be below 600 defects per MLOC.

Figure 5: Post Release Safety-Critical or Security Defects Compared to Total Defects

Tracking defects at the necessary level of detail requires that all steps in the development lifecycle are tooled to capture metrics. All participants in the lifecycle share a common understanding of what constitutes a defect and how it is to be handled. Participants in each step of the process are focused on identifying and addressing defects. To develop comparisons among projects and evaluate quality and security results the following are needed:

- a measure of defects identified and removed during each phase of the lifecycle

- a measure of defect data after code completion (Specifically, defects are tracked and recorded accurately during development, internal or independent verification and validation [V&V], production use, and ideally during build and integration.)

- a measure of operational program size (e.g., source LOC or function points) that can be used as a normalization factor for released systems so that a comparable level of quality across different software systems can be established

3.2 Defect Prediction Models

Defect prediction models should be developed from measures of defect discovery in prior projects. That way, the number of defects can be estimated at the very beginning of the project and updated as defect discovery and removal information is found. Defect prediction models that are first applied in testing have wide error variations and are not useful in judging overall product quality.

Defect prediction models are typically informed by measures of the software product at a specific time, longitudinal measures of the product, or measures of the development process used to build the product. Metrics typically used to analyze quality problems can include

- static software metrics, such as new and changed LOC, cyclomatic complexity,[9] counts of attributes, parameters, methods and classes, and interactions among modules

- defect counts, usually found during testing or in production, often normalized to size, effort, or time in operation

- software change metrics, including frequency of changes, LOC changed, or longitudinal product change data, such as number of revisions, frequency of revisions, numbers of modules changed, or counts of bug fixes over time

- process data, such as activities performed or effort applied to activities or development phases

Many models currently in use rely on static or longitudinal product measures, such as code churn. Other approaches use historic performance or experience based on defect injection and removal (generally described using a "Tank and Filter" metaphor) to monitor and model the defect levels during the development process.

Figure 6: "Tank and Filter" Quality Tracking Model

Low levels of defects in product use require that defects injected into the product must be removed prior to use. We can estimate the level of remaining defects by estimating the injection rates during development and the effectiveness of removal activities. The estimates can be based on historic data and measures. Developers using TSP have accurately predicted their injection

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9   http://en.wikipedia.org/wiki/Cyclomatic_complexity

rates and removal yields and measured the effects of process changes on outcomes [Davis 2003]. The following histogram displays the measured defect removal in design, code, and unit tests for 114 projects from the TSP database. Those achieving levels below 1 defect per KLOC (1000 per MLOC) in system test can be considered to have good quality. It is important to note that testing is used to confirm defect removal and not to identify and fix defects. Further discussion of why quality results cannot rely on testing is provided in Appendix B.

Figure 7:   Defect Removal Densities During Development

Defects are injected when a product is created (design and code) and defects are removed during review, inspection, and test activities. Benchmarks from TSP data show that defect injection rates (defects per hour) are very consistent within development teams providing a basis for prediction of defects in new development or updated code. Quality is planned for the development cycle step. Measurement of defects occurs at each removal stage and is compared to planned levels. A wide range of information is collected about the process and results to ensure that collected data is accurate.

Defect prediction models are typically used to reduce cost and schedule for development by identifying problems earlier in the development cycle when it is less costly to address them. The precision level of the model (potential for false positives [bogus defects] and negatives [missed defects]) can be adjusted depending on whether the development effort is risk-adverse or cost-adverse [Shin 2011].

3.3 In-Depth Analysis: Security Focused Example (Project A1)

The objectives of this project were to update and modernize the Selective Service System and satisfy FISMA [NIST 2002] requirements. Based on the success of the implementation and a security review performed by senior information security experts, the contractor, Advanced Information Systems, received the Government Information Security Leadership Award (GISLA) [Romo 2013].

The project preparation included *ISC²-Certified Secure Software Lifecycle Professional Training[10]* for the staff. The developers implemented the following techniques:

> *"[D]evelopers should be supported by being provided with the necessary knowledge about security vulnerabilities and how they can occur throughout the life cycle. This information should be institutionalized into the way that developers do their work, by being built into the types of quality checks [emphasis added] that get deployed as the software is developed, whether it be on checklists for inspections or other approaches." [Shull 2013]*

Staff members were trained to recognize common security issues in development and required to build this understanding into their development process. Metrics were collected using review and inspection checklists along with productivity data. These metrics allowed staff to accurately predict the effort and quality required for future components using actual historical data.

3.3.1   Security Example Results

The implemented product contained a total of 570 defects (0.97 defects/KLOC), none of which resulted in operational system downtime [Ratnaraj 2012]. The system passed all security audits and had no reported vulnerabilities in production.

Leading indicators of software quality included 76% of components, which were defect free after unit test and had a process quality index (PQI) of >0.37 for database components, >37% for middle tier components, and >0.25 for user interface components [Humphrey 2000]. With PQI values above about 0.4, program modules are generally defect free. The PQI is a derived measure that characterizes the quality of a software development process and is the product of five quality profile component values:

1. **Design quality** is expressed as the ratio of design time to coding time.
2. **Design review quality** is the ratio of design review time to design time.
3. **Code review quality** is the ratio of code review time to coding time.
4. **Code quality** is the ratio of compile defects to a size measure.
5. **Program quality** is the ratio of unit test defects to a size measure.

3.3.2   Security Example Discussion

Among the five projects selected for analysis, this project was the outlier with a higher measured defect density. Although the production defect density of <0.1 defects/KLOC would normally be considered to be quite good [Binder 1997], the level for this system is more than twice that of others in the investigation set. The components are close to, but do not achieve the PQI level of merit, which is generally considered to be >0.4 [Humphrey 2000]. The question then becomes how this product achieves zero reported operational vulnerabilities. To answer that question, we needed to analyze the data further.

Given the product size of approximately 600 KLOC and 0.1 defects/KLOC in production, we infer approximately 60 defects were discovered in production. Using the higher end of the vulnerability/defect range reported from various sources [Alhazmi, Malaiya, and Ray 2007; Alhazmi and Malaiya 2008], 5% to 10%, or 3 to 6 vulnerabilities, should be expected. However, the lower end of the range, 1% or below as observed among systems known to use secure development practices, would project <1 escaped vulnerability.

3.3.3   Security Example Summary

The data from this project indicates that the combination of measured defect density and size is most consistent with no further vulnerabilities identified if we use a vulnerability-to-defect ratio of approximately 1% or lower. The observation of zero vulnerabilities in this system tends to support the conjecture that systems built with a deliberate focus on quality, training to recognize security issues, and evidence of sufficient quality to verify the practice, can use the 1% ratio as a measured defect density to estimate vulnerabilities.

3.4 In-Depth Analysis: Safety-Focused Examples (Projects D1, D2, D3)

Three cases in our data set involve medical diagnostic devices. The devices are used for medical analysis in areas such as immunoassay and hematology. The sources for this project summary include the data recorded by the teams during their time working on the project, their cycle post mortem (retrospective) reports, and a summary presented at the TSP Symposium 2012.[11]

Medical devices are regulated by the FDA, subject to FDA 21 CFR 820 Quality System Regulation,[12] which is a basic regulatory requirement with which all manufacturers of medical devices distributed in the U.S. must comply. The regulation includes the Quality System Regulation (QSR) and Good Manufacturing Practices (GMP).

The QSR includes requirements related to the methods used in and the facilities and controls used for *designing*, purchasing, manufacturing, packaging, labeling, storing, installing, and servicing medical devices. Manufacturing facilities undergo FDA inspections to assure their compliance

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[11]   Grojean, Carol & Robert Musson, RSM 2.5 Project Results (private report).

[12]   http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfcfr/CFRSearch.cfm?CFRPart=820

with QSR requirements. REGULATION Subpart B—Quality System Requirements Sec. 820.22 Quality Audit includes the following requirement:

> *Each manufacturer shall establish procedures for quality audits and conduct such audits to assure that the quality system is in compliance with the established quality system requirements and to determine the effectiveness of the quality system.*

The QSR includes *design controls* that must be demonstrated during the design and development of the device. Additional guidance is provided by *General Principles of Software Validation; Final Guidance for Industry and FDA Staff* [FDA 2002].

The software projects in this study were of size 2.8 MLOC, 1.3 MLOC, and 0.9 MLOC. The largest of the three projects included a large body of legacy code that was in test for an extended time (>8 months) because defect detection rates were not decreasing.

3.4.1   Safety Examples Process Approach

Each of the projects included both new development and enhancements to existing code. Although the process steps were similar, the parameters for the overall development rate and defect injection rates differed among the projects. All projects included the use of static code analysis tools to establish defect levels, primarily for the analysis of legacy code. All projects included checklist-driven reviews of requirements, designs, code, and test cases. Peer inspection processes (design inspection and code inspection) included a safety specialist whose primary role was to evaluate defects for potential safety implications.

The general workflow for the projects was similar to that shown in Figure 8 for quality and security, where each process step includes peer reviews and expert inspection (safety or security).

Workflow for Quality and Software Assurance

Design
- Requirements Capture
- Design
- Design Review → Find and Eliminate Defects
- Design Inspection → Find and Eliminate Defects

Coding
- Code
- Code Review → Find and Eliminate Defects
- Code Inspection → Find and Eliminate Defects
- Unit Test

Verification and Validation
- WI Test
- System Test → Release

Figure 8:   Quality and Security-Focused Workflow

In addition, static analysis tools were used for legacy code as needed after each round of V&V. Legacy modules with defects in the V&V phase were subjected to code inspections for defect identification and removal. Two commercial static analysis tools were used (from Coverity and Klocwork). In the smallest of the three projects, the static analysis tools were applied prior to code review to provide an indicator of potential defects.

Test coverage tools were used for test case development. In addition, test cases were reviewed by the developer and inspected by peers. In practice, 80% of defects that test cases were designed to identify were removed prior to test-case execution. Testing was used to confirm defect removal, not to find defects.

The teams performed detailed planning for each upcoming code release cycle and confirmation planning for the overall schedule. For the project with the largest code base, a Monte Carlo simulation was used to identify a completion date within the 84th percentile (i.e., 84% of the project simulated finished earlier than this completion date) and included estimates for

- incoming software change requests (SCRs) per week
- triage rate of software change requests
- percentage of SCRs closed
- development work (SCR assigned) for a cycle
- SCR per developer (SCR/Dev) per week
- number of developers
- time to develop of test protocols
- software change requests per safety verifier & validator (SCR/SVV) per week
- number of verification persons

The team then committed to complete the agreed work for the cycle, planned what work was being deferred into future cycles, and projected that all remaining work would still fit the overall delivery schedule. All defects were tracked throughout the projects in all phases (injection, discovery, and fix data). Developers used their actual data to plan subsequent work and reach agreement with management on the schedule, content, process used, and resources required so that the plan could proceed without compromising the delivery schedule.

For the development phases, Table 2 lists the percentage of defects removed by phase (as recorded) for three projects.

Table 2:   Percentage of Defects Removed by Phase for Three Projects

Phase	Product 1 0.9 MLOC	Product 2,1.3 MLOC Code and Design Defects Only	Product 3 3.0 MLOC
Static Analysis	4%	0%	0%
Unit Test	8%	17%	26%
Personal Review	24%	23%	27%
Peer Inspection	38%	60%	80%
Integration Test	32%		

In product one, 8% of reported defect fixes failed later verification. This failure represents a "breakage" or "bad fix" ratio. In product two, the developers spent 2/3 as much time in reviews as in development and 40% as much effort in design as code.

For product three, the largest software product, inspections averaged approximately 170 LOC/hour with a defect identification rate of roughly 0.4 defects per hour and a defect removal

density of 4 defects/KLOC. The inspection percentage of total defects identified ranged from 40% to 80%. Typical component defect density was under 1 defect per KLOC entering the V&V phase. Few defects were recorded by the safety inspectors.

The largest of the three projects was completed in 12 months, within 4% of the planned schedule. The focus on quality also improved product reliability. One measure of the reliability improvement for the product was the mean test cycles between defects. This measure grew by a factor of 10 over the 12 months as shown in Figure 9.

Figure 9: Testing Reliability Results for the Largest Project

In the same time period, the portion of defect fixes that failed verification also declined by roughly a factor of 2 as shown in Figure 10.

Figure 10: Re-Fix Rate for the Largest Project

With several hundred units fielded, the mean time between operational failures increased with each subsequent product release as shown in Figure 11.

Figure 11: Operational Reliability for the Largest Product

3.4.2   Safety Examples Discussion

Personal review and peer inspections provided the primary means of defect removal. Tools (e.g., static analysis tools) were used primarily to confirm improvement. Programmers were trained to identify defects and expected to not rely heavily on tools, but to use them as a confirmation. It was reported that the use of the static analysis tools seems to contribute primarily to the identification of "false" defects.

Although the percentage of defects found by testing were high, except for the smallest project, few of the defects were found in the V&V phase. Over 90% of the defects had been removed prior to test. This removal may have positively affected the high test yields because

1.   large numbers of tests could be developed and run

2.   tests were able to focus on appropriate types of defects, as the "nuisance" defects had already been removed

The steps required to achieve lower levels of defects in test included design review and inspection (to reduce injections), personal reviews, and peer inspections. Static analysis was applied primarily to the legacy components.

The root cause analysis for identified defects indicated that most common defects associated with "Level 1," the highest severity category that would lead to a product recall, were found to have been injected during the coding phase. For these projects, a focus on coding quality was determined to be an effective strategy for reducing the risk of released safety-critical defects. This type of root cause analysis is useful because designers and developers have a tendency to repeat the same types of mistakes, so defect removal efforts should be focused to offset these injections as much as possible [Humphrey 2000].

3.4.3   Safety Examples Summary

These products focused on safety rather than security as the driving quality attribute. Like the security-focused projects, the development teams defined quality as the absence of defects. Also

like the security projects, designs, review checklists, and the test process were tailored for the types of defects most important to the project.

The teams in this study developed and followed quality plans supported by explicit resource plans and schedules and demonstrated by metrics. The plans included personal reviews, peer inspections, static analysis, and a rigorous test case development process, including code coverage analysis and inspection of the test cases. The teams were able to execute their plan by allocating and agreeing to sufficient schedule time and effort, collecting measures throughout the process to monitor their work. The results suggest that products with very low levels of defects are associated with a disciplined approach to planning quality activities, funding them properly, and faithfully implementing the plan.

4 Assurance and Finding Defects

Assuring that a software component has few defects also depends on assuring our capability to find them. Positive results from security testing and static code analysis are often provided as evidence that security vulnerabilities have been reduced, but the vulnerabilities discussed in this section demonstrate that it is a mistake to rely on them as the primary means for identifying defects. The omission of quality practices, such as inspections, can lead to defects that can exceed the capabilities of existing code analysis tools.

In the first example, an Apple coding vulnerability was likely the result of careless editing. The second example is the Heartbleed vulnerability in OpenSSL[13] (an open source implementation of the secure socket layer protocol). Heartbleed is a good example of the limited effectiveness of current software assurance tools. Kupsch and Miller noted that, "Heartbleed created a significant challenge for current software assurance tools and we are not aware of any such tools that were able to discover the Heartbleed vulnerability at the time of announcement" [Kupsch 2014]. There are techniques that can be applied during development that would have prevented the injection of these vulnerabilities.

4.1 Case Study: Apple Coding Vulnerability

In 2014, Apple fixed a critical security vulnerability that was likely caused by the careless use of "cut and paste" during editing.[14] The programmer embedded a duplicate line of code that caused the software to bypass a block of code that verifies the authenticity of access credentials. Researchers discovered this security flaw in iPhones and iPads; Apple confirmed that it also appeared in notebook and desktop machines using the Mac OS X operating system. The vulnerability is described in the National Vulnerability Database[15] as follows:

> *Impact: An attacker with a privileged network position may capture or modify data in sessions protected by SSL/TLS*
>
> *Description: Secure Transport failed to validate the authenticity of the connection. This issue was addressed by restoring missing validation steps.*

This vulnerability would allow an attacker to use invalid credentials to gain access to any information on the targeted device, such as email, financial data, and access credentials to other services. A variety of standard quality techniques could have prevented or identified the defect. The defect could have been identified during a personal review by the developer or during a more formal and effective peer review.

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13   CVD id CVE-2014-0160 (MITRE; National Vulnerability Database) http://web.nvd.nist.gov/view/vuln/detail?vulnId=CVE-2014-0160

14   http://web.nvd.nist.gov/view/vuln/detail?vulnId=CVE-2014-1266

15   http://nvd.nist.gov/

The faulty source code (with the error highlighted) is as follows:

```
static OSStatus
SSLVerifySignedServerKeyExchange(SSLContext *ctx, bool isRsa, SSLBuffer
signedParams,uint8_t *signature, UInt16 signatureLen)
{OSStatus    err;
    ...
    if ((err = SSLHashSHA1.update(&hashCtx, &serverRandom)) != 0)
        goto fail;
    if ((err = SSLHashSHA1.update(&hashCtx, &signedParams)) != 0)
        goto fail;
        goto fail;
    if ((err = SSLHashSHA1.final(&hashCtx, &hashOut)) != 0)
        goto fail;
    ...
fail:
    SSLFreeBuffer(&signedHashes);
    SSLFreeBuffer(&hashCtx);
    return err;}
```

There are a number of structured development techniques that, if applied consistently, could have identified and possibly prevented this security coding defect as well. For example techniques such as these:

- designing code to minimize branching and make it more predictable and testable
- architecting the design specification to become the basis for verifying code, including but not limited to requirements analysis and test

These techniques are excellent strategic recommendations to improve quality in general, but are neither effective nor efficient for detecting a mistake likely created by carelessness. The same conclusion would apply to recommendations such as (1) provide better training for the coders, (2) use line-of-code coverage test cases, or (3) use path-coverage test cases. Using static analysis to identify dead code is a technique that could flag this defect, but the high false-positive rate for this type of approach would make it a far more expensive effort than effective editing of code during a personal review, an informal peer code review, or a formal peer code inspection.

The application of simple coding rules, such as "use braces for the body of an 'if', 'for', or 'while' statement" or automatically format the source code to reflect its structure so that the source appears as

```
    if ((err = SSLHashSHA1.update(&hashCtx, &signedParams)) != 0)
        goto fail;
    goto fail;
    if ((err = SSLHashSHA1.final(&hashCtx, &hashOut)) != 0)
        goto fail;
```

could also increase the likelihood that such a defect is found during a review. However, a thorough review is still needed.

4.2 Case Study: Heartbleed Vulnerability

The vulnerability referred to as Heartbleed occurred in the OpenSSL "assert" function, which is the initiator of a heart-beat protocol to verify that the OpenSSL server is live. OpenSSL is an open-source implementation of the secure socket layer (SSL) and transport layer security (TLS) protocols used for securing web communications. Assert software sends a request with two parameters, a content string (payload) and an integer value that represents the length of the payload it is sending. The expected response, if the OpenSSL connection is available, is a return of the content string for the length specified.

The protocol assumes that the requested length of the payload returned is less than 65535 and less than or equal to the payload length, but those assumptions are never verified by the responding function.

A consequence of a violation of either of these limitations is that the request can trigger a data leak. The XKCD[16] comic shown in Figure 12 contains a simple explanation of what happens in the code. Rather than a buffer overflow, we have what is called an over-read. The security risk is that the additional data retrieved from the server's memory could contain passwords, user identification information, and other confidential information.

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16   http://xkcd.com/1354/

Figure 12: Heartbleed Protocol[17]

The defect appears to have been accidentally introduced by a developer in December 2011. OpenSSL is widely used as a convenient (and free) tool. At its disclosure, some half a million of the Internet's secure web servers certified by trusted authorities were believed to have been vulnerable to the attack.[18] The new OpenSSL version repaired this vulnerability by including a bounds check to make sure the payload length you specified is no longer than the data you actually sent.

The Security and Privacy article "Heartbleed 101" provides an excellent summary of why this vulnerability was not found sooner, even with the use of static analysis tools [Carvalho 2014]. The designer of each static analysis tool has to make trade-offs among the time required for the analysis, the expert help required to support the tool's analysis, and the completeness of the analysis. Most static analysis tools use heuristics to identify likely vulnerabilities and to allow completion of their analysis within useful times. Static analysis tools can be an effective technique for finding some types of vulnerabilities, but the complexity of the OpenSSL code includes multiple levels of indirection and other issues that simply exceeded the capabilities of existing tools to find the vulnerability [Carvalho 2014].

While the OpenSSL program is complex, the cause of the vulnerability is simple. The software never verified the design assumption that the length of the content to be returned to the caller was less than or equal to the length of the payload sent. Verifying that the input data meets its specification is a standard activity performed for quality, not just for security.

This example also exhibits the realistic trade-offs that must occur between the effort associated with applying a technique and the improved quality or security that is achieved (i.e., the efficiency and effectiveness of the techniques relative to the type of defect). As noted by McGraw, incorporating automated code analysis into the development lifecycle encounters a number of issues of scale [McGraw 2014]. Resource requirements have increased as tools have matured to cover a broad range of vulnerabilities; it may not be feasible to run them on a desktop computer. Scans alone can take two to three hours, which must be followed by analysis of the output to identify and fix vulnerabilities. These resource requirements pose difficulty for some uses, such as Agile development.

One of the benefits touted of Open Source, besides being free, has been the assumption that "having many sets of eyes on the source code means security problems can be spotted quickly and anyone can fix bugs; you're not reliant on a vendor" [Rubens 2014]. However, the reality is that without a disciplined and consistent focus on defect removal, security bugs and other bugs will be in the code. The resources supporting OpenSSL had limited funding and inconsistent results. "No one was ever truly in charge of OpenSSL; it just sort of became the default landfill for prototypes of cryptographic inventions, and since it had everything cryptographic under the sun, it also became the default source of cryptographic functionality."[19]

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[18]   http://en.wikipedia.org/wiki/OpenSSL

[19]   http://en.wikipedia.org/wiki/OpenSSL

The examples in this section show that quality practices, such as inspections and reviews of engineering decisions, are essential for security. The associated software weaknesses in these examples should have been identified during development. Testing and code analyzers must be augmented by disciplined quality approaches. Appendix A provides a summary of the research available that connects vulnerabilities and defects. Though there is insufficient evidence to confirm a mathematical relationship, for estimating purposes, 1-5% of defects should be considered to be possible vulnerabilities.

5 Other Data Sources: Security, Quality, and Reliability

A report by The National Supervisory Control and Data Acquisition (SCADA) Test Bed (NSTB) program on common industrial control systems (ICS) security weaknesses noted that secure design and vulnerability remediation activities have been judged by many organizations as undoable due to time, cost, and backward compatibility issues.

That observation by the NSTB report is supported by research conducted by IOActive in 2013 that focused on analyzing and reverse engineering the freely and publicly available firmware updates for popular satellite communications (SATCOM) technologies manufactured and marketed by well-known commercial firms. The IOActive report identified a number of critical firmware vulnerabilities shown in Table 3.

Table 3: Vulnerability Classes

Backdoors	Mechanisms used to access undocumented features or interfaces not intended for end users
Hardcoded Credentials	Undocumented credentials that can be used to authenticate in documented interfaces expected to be available for user interaction
Insecure Protocols	Documented protocols that pose a security risk
Undocumented Protocols	Undocumented protocols or protocols not intended for end users that pose a security risk
Weak Password Resets	A mechanism that allows resetting others' passwords

The last two items in this table could require some security expertise, but the first three items are well-known security vulnerabilities whose existence supports a claim that security received little attention during development. For example, *hardcoded credentials,* is 7th on the *2011 CWE/SANS Top 25 Most Dangerous Software Errors* [Christey 2011]. Backdoors often appear when code inserted for debugging is not removed before deployment or when code is added for remote system administration, but not properly secured.

5.1 Quality Practices

5.1.1 Design and Engineering Defects

Two safety examples show the importance of applying quality measures to engineering design decisions.

Studies of safety-critical systems, particularly DoD avionics software systems, show that while 70% of errors in embedded safety-critical software are introduced in the requirements and architecture design phases [Feiler 2012], 80% of all errors are found only at system integration or later. In particular, these errors are not found in unit testing. The rework effort to correct requirement and design problems in later phases can be as high as 300 to 1,000 times the cost of in-phase correction; undiscovered errors are likely to remain after that rework.

Similar problems appeared with patient-controlled analgesia infusion pumps that are used to infuse a pain killer at a prescribed basal flow rate. The U.S. Federal Drug Administration (FDA)

uses a premarket assessment to certify the safety and reliability of medical infusion pumps before they are sold to the public. In spite of the FDA's assessment, too many approved pumps exhibited hardware and software defects in the field, leading to the death or injury of patients.[20] From 2005 through 2009, 87 infusion pump recalls were conducted by firms to address identified safety problems. These defects had not been found during development by testing and other methods. Based on an analysis of pump recalls and adverse events, the FDA concluded that many of the problems appeared to be related to deficiencies in device design and engineering. The FDA revised its re-market assessment to also consider defects in device design and engineering.

5.1.2   Capers Jones Software Quality Survey

Capers Jones has analyzed the effects that general practices, such as inspections and static analysis, have on improving software quality [Jones 2012].

Table 4 lists the practices associated with poor quality software—less than a 25% success rate for improving quality and good results—greater than a 95% success rate for improving quality. The best results are associated with a combination of these techniques (i.e., the results of a combination of techniques increases the assurance associated with the design and implementation).

Table 4:   Quality Practices Study

Poor Results		Good Results	
Testing as only form of defect removal	LOC Metrics for quality (omits non-code defects)	Formal inspections (requirements, design, and code)	Code static analysis
Informal testing and un-certified test personnel	Failure to estimate quality or risks early	Requirements modeling	Testing specialists (certified)
Testing only by developers; no test specialists	Passive quality assurance (< 3% QA staff)	Defect detection efficiency (DDE) measurements	Root-cause analysis
LOC metrics for quality (omits non-code defects)		Defect removal efficiency (DRE) measurements	Active quality assurance (> 3% SQA staff)
		Automated defect tracking tools	

5.1.3   Consortium for IT: Software Quality (CISQ)

The Consortium for IT: Software Quality (CISQ) developed specifications for automating the measurement of software reliability, security, performance efficiency, and maintainability that complements static analysis [CISQ 2012]. The CISQ assessment of the structural quality of software is based on applying rules of good coding practices (Quality Rules). The Quality Rules for security are drawn from the CWE as examples of violations of good practices. For example, CWE-129 is improper validation of an array index. CISQ selected CWE entries associated with vulnerabilities in the CWE/SANS 25 and the OWASP Top Ten lists.[21]

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[20]   U.S. Food and Drug Administration. Guidance for Industry and FDA Staff Total Product Life Cycle: Infusion Pump Premarket Notification [510(k)] Submissions (Draft Guidance), 2010.

[21]   https://www.owasp.org/index.php/Top_10_2013-Top_10

The CWE describes multiple ways to mitigate many of the weaknesses. For example, consider CWE-89, which is addressed by Rule 2 shown in Table 3 for your convenience (a subset of the CISQ Security Rules). A Standard Query Language (SQL) injection occurs when user input is used to construct a database query written in SQL. A poorly written input validation function can enable an attacker to access, change, or add entries to the database by including SQL expressions in the input provided.

An experienced programmer can write an input routine that identifies SQL expressions in the input data. It is difficult to verify that a programmer-written routine prevents an SQL injection. Instead, the CISQ Quality Rule follows the CWE mitigation to use a vetted library or framework that is known to mitigate this vulnerability. The validation of the use of such a library can be automated and does not require the coder to have extensive security expertise.

Table 5:   A CISQ Security Rule

Issue	Quality Rule	Quality Measure Element
CWE-89: Improper Neutralization of Special Elements used in an SQL Command ('SQL Injection')	**Rule 2:** Use a vetted library or framework that does not allow SQL injection to occur or provides constructs that make this SQL injection easier to avoid or use persistence layers such as Hibernate or Enterprise Java Beans.	**Measure 2:** # of instances where data is included in SQL statements that is not passed through the neutralization routines.

The CISQ approach, like static analysis, is based on the analysis of developed source code; but there is a significant difference between using the Quality Rules and applying static analysis. The Quality Rules incorporate software engineering recommendations, such as the use of vetted libraries, thereby preventing specific vulnerabilities rather than identifying defects after they have been created.

Given a high-risk and frequently used vulnerability such as an SQL injection, a designer might be asked the following question during a security review:

Are you sure that SQL injections have been mitigated?

This assurance question is asked to determine the level of confidence the designer has that the vulnerability has been mitigated. The designer could provide an argument and evidence to justify that claim (i.e., an assurance case). The argument is based on an engineering decision to use a library of functions that have been shown to mitigate SQL Injections—CISQ Rule CWE-89 shown in Table 5. This engineering choice is effective only if the implementation has used the library functions. A tool provided by CISQ to scan the software provides evidence that the implementation has used the library functions. A graphical representation of the designer's response appears in Figure 13.

Figure 13: CISQ Assurance

Defect prevention typically depends on analysis that extends beyond a single software component. As noted by OMG, detecting backdoors, cross-site scripting vulnerabilities (XSS), or unsecure dynamic SQL queries through multiple layers requires a deep understanding of all the data manipulation layers as well as the data structure itself [OMG 2013]. Overall, security experts Greg Hoglund and Gary McGraw believe that cross-layer security issues account for 50% of all the security issues [Hoglund 2004].

A security analysis needs to consider what OMG refers to as *system level analysis*, the ability to analyze all the different code units and different layers of technology to get a holistic view of the entire integrated business application. System-level analysis allows us to visualize complete transaction paths from user entries, through user authentication and business logic, down to sensitive data access.

6 Planning for Improved Security and Quality

The projects we analyzed pointed to a disciplined lifecycle approach with quality defect identification and removal practices combined with code analysis tooling to provide the strongest results for building security into software and systems. Examples, such as the recent Apple bug, support the need for strengthening code review. Heartbleed points to the need for validating that all requirements are complete and fully implemented in the code. The five projects selected from the SEI TSP database demonstrated that producing products with very few operational issues requires an integration of quality reviews for defect removal, including security or safety-critical reviews at every step of the lifecycle.

The effectiveness of quality practices, such as inspections, in finding defects depends on reviewers who are knowledgeable in what could go wrong. The CISQ Quality Rules show that effective security engineering decisions need to augment developer capabilities.

The SEI conducted a workshop in August 2014 with representatives from the organizations that delivered TSP quality results as well as industry and federal acquisition, engineering, and security experts interested in further analysis of these success stories. Their discussion, based on shared experiences that support the need for increased quality as one means for improved software security, led to the following insights:

- If you have a quality problem, then you have a security problem.

- Maybe up to 70% of CWEs are actually quality defects.

- Maturity levels are based on statistical samples; quality requires continuous measurement of everything to catch problems early.

- If something is important, then you have to figure out a way to measure it; quality has established an intensive metrics-collection process for all aspects of the lifecycle and security can leverage many of these same metrics, but doing so requires investment in extensively tooling the processes used to acquire, develop, validate, and implement systems.

- Effective measurements require planning to understand what to measure and what the measures tell you; then you can track results and understand when your efforts are or are not achieving intended outcomes.

- Quality and security use the same automated tools and testing approaches but the focus is different:
  - For quality, the level of defects is an indicator of code quality; testing is not for finding bugs, but for confirming quality.
  - For security, the tools are used in testing to point to specific problems and many false positives result in wasted time researching non-problems.

- Quality approaches instill personal accountability at each stage of the lifecycle; the enterprise must clearly define what "right" looks like and then measure and reward the right behaviors, which are reinforced by training, tracking, and independent review.

Our research suggests that implementing systems with effective operational security requires incorporating both quality and security considerations throughout the lifecycle. Predicting effective operational security requires quality and reliability evidence and security expert analysis at each step in the lifecycle. If defects are measured, from 1-5% of them should be considered to be security vulnerabilities. It is also feasible that when security vulnerabilities are measured, then code quality can be estimated by considering them to be 1-5% of the expected defects.

6.1 Next Steps

Further evaluation of systems is needed to see if the patterns suggested by our analysis continue to hold. We explored several options to expand our sample size, but found limited data about defects and vulnerabilities assembled in a form that could be readily analyzed. This analysis must be done for each unique version of a software product. At this point in time, evaluation of each software product requires careful review of each software change and reported vulnerability. The review not only matches up defects with source code versions, but also reviews each vulnerability reported against the product suite to identify defects specific to the selected product version by parsing available description information and identifying operational results for the same source code. Collection of data about each product in a form that supports automation of this analysis would greatly speed confirmation.

Appendix A: Relationship Between Vulnerabilities and Defects, a Brief Summary of the Literature

A number of publications, many peer reviewed, support, or are consistent with the thesis that a large portion of vulnerabilities result from common development errors, and therefore, vulnerabilities correlate with defects.

In 2004 Jon Heffley and Pascal Meunier, reported that 64% of vulnerabilities in the National Vulnerability Database (NVD) resulted from programming errors; half of those errors were in the categories of buffer overflow, cross-site scripting, and injection flaws [Heffley 2004].

In 2006, Li reported empirical findings on the sources of vulnerabilities and found that 9-17% of vulnerabilities were memory related; of those vulnerabilities, 72-84% were semantic rather than syntactic [Li 2006]. The median time between introduction and discovery of the vulnerability was between two and three years. The semantic vulnerabilities include cross-site scripting and injection errors. In his paper, Li specifically recommended using tools to examine code prior to release.

In 2014, Robert Martin summarized empirical findings from the CWE (MITRE) linking vulnerabilities to common development issues. In his article, Martin includes a number of activities that are effective in finding and removing defects earlier in the process [Martin 2014].

In a 2011 empirical study of the Firefox browser, Shin and Williams reported that 21.1% of files contained faults and 13% of the faulty files (3.3% overall) were vulnerable. They further reported that 82% of the vulnerable files were also classified as faulty [Shin 2011]. They concluded that that "prediction models based upon traditional metrics can substitute for specialized vulnerability prediction models." Despite the correlation and high recall, a large portion of false positives remained, indicating that further research is needed to identify vulnerabilities.

Figure 14: Distribution of Faulty and Vulnerable Files in Firefox 2.0

In 2007 and 2008, Omar Alhazmi and colleagues investigated the relationship directly, and reported measures of vulnerabilities and defects in versions of Windows and Linux operating systems [Alhazmi 2007, 2008]. Table 6 illustrates their findings.

Table 6:   Vulnerability Density Versus Defect Density Measured for Some Software Systems

Systems	MSLOC	Known Defects	Known Defect Density (per KSLOC)	Known Vulnerabilities	VKD (per KSLOC)	VKD/DKD Ratio (%)	Release Date
Windows 95	15	5000	0.3333	50	0.0033	1.00	Aug 1995
Windows 98	18	10000	0.5556	84	0.0047	0.84	Jun 1998
Windows XP	40	106500	2.6625	125	0.0031	0.12	Oct 2001
Windows NT	16	10000	0.625	180	0.0113	1.80	Jul 1996
Win 2000	35	63000	1.80	204	0.0058	0.32	Feb 2000

Table 7 depicts the results of a 2006 study by Andy Ozment and Stuart Schechter that reported an overall vulnerability density of 6.6 Vuls/MLOC (new and changed LOC) in OpenBSD versions 2.3 through 3.7 [Ozment 2006]. The vulnerability densities are comparable to the vulnerability densities reported by Omar Alhazmi and Yashwant Malaiya for Linux 6.2 [Alhazmi 2008]. Table 8 depicts the results of the 2008 study conducted by Alhazmi and Malaiya.

Table 7:   Vulnerability Density in OpenBSD Versions 2.3 - 3.7

Systems	MLOC	OS Type	Known Vulnerabilities	Vulnerability Defect Density (per KLOC)	Release Date
Windows 95	15	Commercial client	51	0.0034	Aug 1995
Windows XP	40	Commercial client	173	0.0043	Oct 2001
R H Linux 6.2	17	Open-source	118	0.00694	May 2000
R H Fedora	76	Open-source server	154	0.00203	Nov 2003

Table 8:   Vulnerability Density Results from 2008 Study

Systems	MSLOC	Known Defects	Known Defect Density [Defects/KSLOC]	Known Vulnerabilities	V/KSLOC	V/D (%)
Windows 95	15	5000	0.3333	50	0.0033	1.0
Windows 98	18	10000	0.5556	84	0.0047	0.84
Windows XP	40	106500	2.6625	125	0.0031	0.12
Windows NT	16	10000	0.625	180	0.0113	1.8
Win 2000	35	63000	1.8	204	0.0058	0.32
Apache	0.376	1380	3.670212766	132	0.351064	9.565217
RH Linux 6.2	17	2096	0.123294118	118	0.00694	5.628817
RH Linux 7.1	30	3779	0.125966667	164	0.005467	4.339772
RH Fedora	76			154	0.00203	

The mean value of V/D is 2.9 % with a standard deviation of 3.3. Because the distribution is skewed, the non-parametric statistics may be more relevant. The median value is 1.4 with 75% of the values between 0.32% and 5.6%
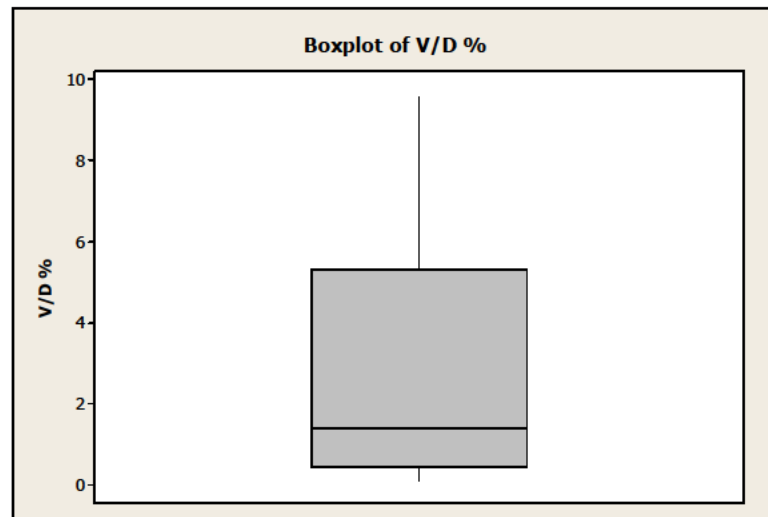

Figure 15: Boxplot of V/D%

Conclusions from the Literature

The NVD, CVE, and CWE are imperfect tools for research since the goal is for volunteers to record the known vulnerabilities rather than research. The data are often incomplete, redundant, or ambiguous and requires manual coding. Nonetheless, the data provide a useful starting point not only for practitioners, but researchers as well. Common vulnerabilities continue to be associated with coding and design defects of known types, and these vulnerabilities could be identified and removed earlier in the development process. Because these defects are rare—typically in the range of 0.002 to 0.006 per thousand lines of code—the counts may have high uncertainty. The uncertainty is compounded by the observation that vulnerability counts are only for those vulnerabilities so far discovered. This, in turn, is related to the use of the system and the motivation of users and hackers to discover the vulnerabilities. Moreover, lines of code to implement similar capability can vary substantially between systems depending on computing language and coding standards.

Given the sources of uncertainty, and the wide ranges in defect and vulnerability density, the ratio of vulnerabilities to defects is expected. Nonetheless, the association is plausible and appears to exist in practice. The measured vulnerability densities are consistent with vulnerability defect ratios of between 0.3% and 10%. There are some hints that the lower end of this range represents systems that have made greater use of security specific removal tools and development practices.

Appendix B: Quality Cannot Be Tested In

The quality objective is to reduce the number of defects. Testing is a necessary component of a quality-system development lifecycle but is inefficient for large systems and for finding defects that could affect security and reliability.

Testing Is Inefficient

The problem with efficiency is described in this section. In program implementation phases, developers using traditional compiled environments inject approximately 100 defects per 1000 lines of code (KLOC) [Rombach 2008]. With the modern integrated development environment (IDE) and with no visible compile stage, the measured rate is closer to 50 defects per KLOC. This can also be estimated at about 1.5 defects per hour of development time. Since the cost and time required to remove defects in test is very high in comparison to removal using other techniques, it is therefore impractical to remove large numbers of defects during the testing phase.

Late test is extremely expensive. Figure 16 shows data from Xerox that estimates the average marginal cost of 20 task hours to find and fix each defect [Humphrey 2011]. Recent industry data suggest fix rates of 1.6 defects per developer week after a defect has been discovered by test. The difficulty is that a system must be tested, unexpected results logged in the bug-tracking system, the issue must be assigned, the actual source of the fault must be identified before the problem can be corrected, and finally the fix must be retested. High yields are only possible when there are very few defects entering late test since high defect rates would overwhelm the capacity to execute the find, fix it, and retest.
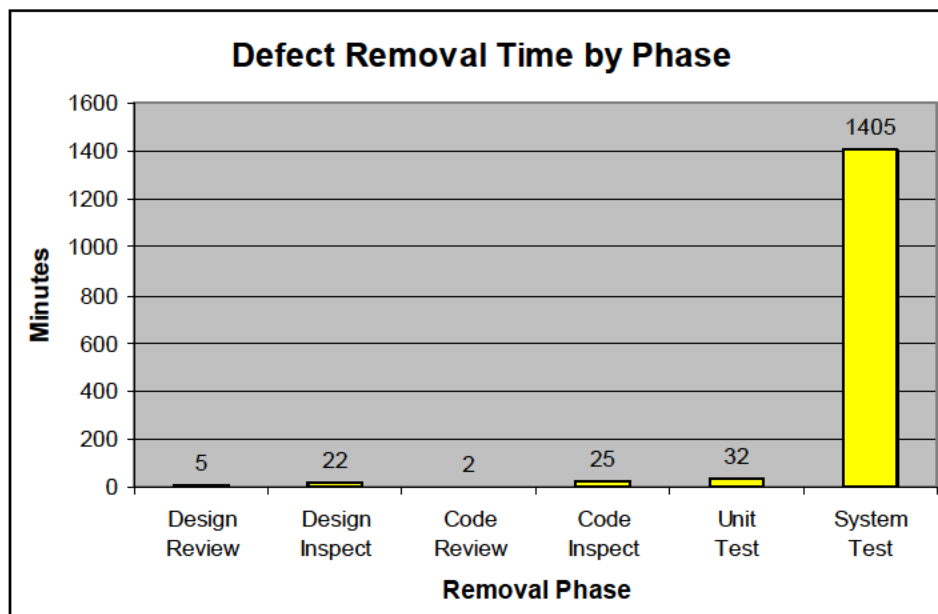

Figure 16: Defect Find and Fix Times from Xerox

System test defect removal times are much greater because in this phase, the system—not a module—is being tested. Simply identifying the defect can be time consuming, ranging from a few minutes to weeks to determine the problem. After the problem is found, the defect must be fixed and the system tested. This process increases makes the average defect removal time in system test about two orders of magnitude more than the average defect removal times for phases before integration and system test.

TSP guidelines suggest entering unit test with less than 5 defects per KLOC. 100,000 LOC would have 2000 defects. To remove half of those defects would require approximately 20,000 task-hours or 20 developer years. This effort is comparable to the cost of initial development. Entering system test with twice that level of defects would require twice as long.

In a world with business constraints on both time and money, test will often end when time and money are exhausted, not when all defects have been found.

Testing Is Ineffective

All defect removal activities have limits, and test is more limited than others. A problem with test is that it has many dimensions. Code must be exercised (often for different input conditions), and different paths (including error handling) must be checked. Covering lines of code, paths, and conditions often explodes combinatorial. Exhaustive test cases are often impossible. Moreover, a variety of conditions that stress the system must be tested as well.

Medium- and large-scale systems typically contain many defects, and these defects do not always cause problems when the software systems are used precisely as tested. The tests, however, cannot be comprehensive because large systems contain many components that operate under many conditions. When systems are stressed in new ways, previously undiscovered defects are encountered. Therefore, under stressful conditions, these systems are least likely to operate correctly or reliably. Figure 17 shows several of the conditions that can stress the program under operation. The circle represents possible ways in which the system can be tested. The axes suggest possible ways that the system can be stressed when testing functionality and performance. These include, but are not limited to, configurations, hardware faults, input error, data errors, and resource contentions. The tested region, presumably safe and secure, is depicted in green. The untested region is potentially unsafe or not secure and is depicted in gray. Even a small system might require an enormous number of tests to confirm correct operations under expected conditions. As systems grow, the total number of possible conditions may be infinite. For any non-trivial system, the tested area is small. Test, by necessity, focuses on the conditions most likely to be encountered and most likely to trigger a fault in the system. Test, therefore, can only find a fraction of the defects in the system. On the other hand, attackers may deliberately attempt to stress the system in unconventional ways.
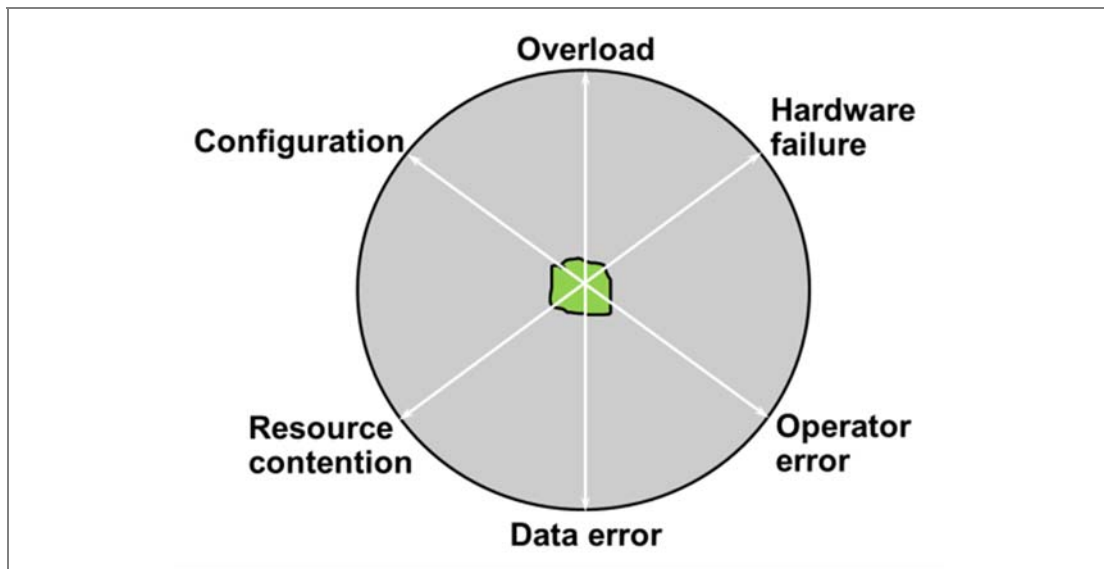
Figure 17: Notional Test Coverage Along Multiple Dimensions

Estimates for the effectiveness of testing be found in Capers Jones' book on the economics of software quality [Jones 2011]. Jones reports observed limits to test efficacy (low, medium, and high).

Table 9:   Typical Defect Removal Effectiveness

	Low	Medium	High
Unit Test	25%	35%	55%
New Function Test	30%	40%	55%
Regression Testing	25%	35%	45%
Integration Test	25%	55%	95%
System Test	25%	55%	95
Stress or Capacity Test	45%	65%	90%
Performance Test	70%	80%	95%

Jones reports that the total defect removal efficiency averages between 85% and 95% depending upon size and domain. Defect potential ranges from two to nine defects per function point of size, with larger products being more defect prone.

To mitigate these shortcomings, the beta test strategy has been widely adopted. In beta test, software is operated by the intended users prior to release [Humphrey 2011]. This approach has been very effective in identifying and fixing problems most likely to be encountered along the commonly executed paths, but the approach relies on the assumption that the user behavior is predictable. The result is a level of defects that users typically find acceptable. Attackers, however, stress the system in unusual ways and target gaps in the test and unexpected paths. Test and beta test, therefore, cannot be relied on to assure security.

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Security vulnerabilities are defects that enable an external party to compromise a system. Our research indicates that improving software quality by reducing the number of errors also reduces the number of vulnerabilities and hence improves software security. Some portion of security vulnerabilities (maybe over half of them) are also quality defects. This report includes security analysis based on data the Software Engineering Institute (SEI) has collected over many years for 100 software development projects. Can quality defect models that predict qual-ity results be applied to security to predict security results? Simple defect models focus on an enumeration of development errors after they have occurred and do not relate directly to operational security vulnerabilities, except when the cause is quality related. This report discusses how a combination of software development and quality techniques can improve software security.

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